

Change from health center to family physician period in the Turkish health system: A qualitative study

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Summary

Introduction: Health care reforms in Turkey have been implemented resolutely in the last 12 years. The shift from health center (HC) to a family physician (FP) approach is 1 of the basic interventions of these reforms. The goal of the current study is to evaluate opinions of patients, health care workers, and managers, using qualitative methods.

Methods: In-depth interviews were conducted with patients who received health care services in both the FP and the HC periods, and with health care workers and managers in health care facilities that served in both periods. The interviews were recorded after obtaining permission, and then transcribed. Both health care staff that worked in the 2 periods and the patients that received health care services in the 2 periods reported that FP system was superior to HC system in attention showed by the family physicians, being followed by the same physician, and having confidence in physicians.

Results: The current FP period is superior to HC in facilities such as patient records, computer, internet, and phone. The strengths of HC period include home visits, environmental health studies, and family planning services. According to health care workers who worked in the 2 periods, HC was superior to FP in team spirit, public service delivery, and surveillance of communicable diseases.

Conclusion: Public service delivery and environmental health studies and primary care practice in rural areas must be scrutinized in the context of the FP approach.

KEYWORDS

community health, health care reform, health policy

1 | INTRODUCTION

Health care reforms date back to 20 years ago; however, these reforms have been implemented more resolutely by the Justice and Development Party governments in the last 12 years in Turkey. The family physician (FP) system is 1 of the basic interventions of these reforms. The FP system was implemented in 2005 as a part of the Health Transformation Program in an attempt to improve primary care services in line with the needs of patients, to place more focus on preventive health care services, to improve personal health records, and to implement the right of choosing a doctor.¹⁻³ With the implementation of the FP system in new provinces after launching the system in 2005, the system became widespread in the country by 2010. The old system, known as the health centers (HC) system, was first launched in the 1960s and ended in 2005 after an operative period of 45 years. The HC system is based on a community-oriented geographical region with a very broad health team. People living in the same region received health care services from the same doctor, but in this system, patients could not select their own doctor.⁴ In summary, the main difference between the HC and FP systems is that in the FP system, people can select their own family doctor, and the team is composed of a single doctor and only 1 nurse or midwife.

In the FP system, new organizations, known as community health centers, were established in 2005 in Turkey to address to the fact that FP was not intended to provide community health services. Community health centers execute community-based programs such as school vaccination campaigns, environmental health services, public education, cancer screening programs, and work to address smoking and obesity. The family physician constitutes the basis for health care reforms. It is therefore important to monitor the outcomes of the interventions using scientific methods, and obtain opinions of the health care receivers, workers, and administrative workers regarding the system. The use of qualitative methods in data collection provides more richly detailed information in evaluation of such political and social practices and system changes. The aim of the current study is therefore to use qualitative methods to explore opinions of patients who received health care services in both the FP and HC periods, and the opinions of health care workers and managers in health care facilities who served in both periods.

2 | METHOD

2.1 | Ethics

The study was conducted in accordance with the World Medical Association Declaration of Helsinki of 1975 (as revised in Edinburgh 2000), with the approval from Manisa Provincial Health Directorate and Dokuz Eylul University Non-Interventional Studies Ethics Committee (2012/11-14). Written informed consent was obtained from all of the patients, health care workers, and health managers.

2.2 | Procedure

The present study is designed as a qualitative study. The research was conducted in the province of Manisa, located in the western part of Turkey and with a population of 1.3 million. The new system (FP) was implemented in the province of Manisa in 2008. In-depth interviews were conducted in 2013 with patients who received health care services in both the FP and HC periods, and with health care workers and health managers in health care facilities who served in both periods. A structured questionnaire was used during the interviews to focus on predetermined topics. The data collection form was prepared in accordance with primary care assessment scales and the principles

of primary health care (PHC) announced in Alma-Ata.⁵ The study themes included coverage, comprehensiveness, continuity, accessibility of health care services, health team, principles of the referral chain, working conditions, in-service training, legislation, finance, and infrastructure.

2.3 | Study participants

Triangulation was conducted by interviewing 3 different types of stakeholder: service providers (physician, midwife, nurse), service users, and health care administrators. The study participants were selected on the basis of the longest working time, gender, and urban/rural residence. Manisa city center was selected as the urban area, and Akhisar and Saruhanlı districts and their villages were selected as the rural area. In total, 38 interviews were conducted (Figure 1).

The interviews were digitally recorded after obtaining permission from the participant. The interviews were conducted by appointment in an appropriate setting for an interview, each lasting for around 1 to 2 hours. Audio recordings were then transcribed.

2.4 | Content analysis

A thematic content analysis was conducted by assigning codes to the text using both a predefined list of themes, and emerging themes and subthemes. We used the Atlas.ti software program for analysis.

3 | RESULTS

The opinions of service users, health care workers, and health care administrators are presented under 4 main themes: health care organization, health staffing, health management, and health finance. We also summarized the main characteristics of the HC and FP periods in Table 1 in the light of these themes.

3.1 | Health care organization

The place of first admission was similar in the 2 periods, and only the name was changed, according to the service users. The place of first admission was family health center (FHC) in FP period and health centers in the HC period.

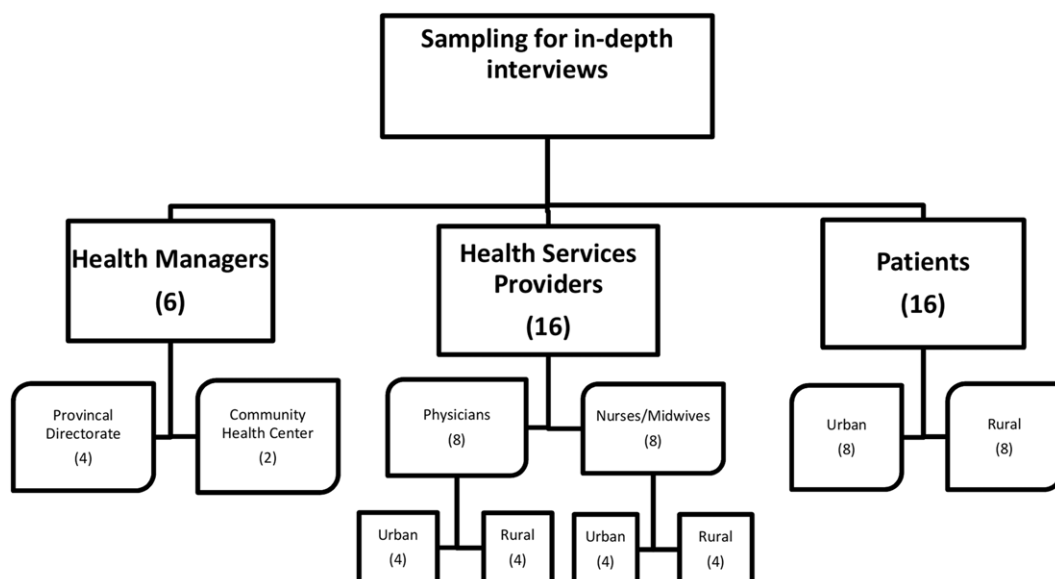


FIGURE 1 Sample size and characteristics

TABLE 1 Summary of findings in health center and family physician periods in Turkey

Health Center Period	Family Physician Period
Place of first admission	Place of first admission
No doctor choice available	Doctor choice available
Waiting times are longer	Waiting times are shorter
Community-based (geographical) service	Per-capita service
General service delivery	Service provided only to registered population
Preventive health care services are provided to the public (based on geography)	Preventive health care services are provided only to registered population
Mobile service is widespread	Mobile service is limited (mobile service only in predetermined days if there is an affiliated rural population)
Enhanced team spirit	Weak team spirit (2-person team)
Rural area-based organization	Urban area-based organization
Community-based service delivery	Individual-based service delivery
No performance assessment	Performance assessment is dependent on some of service delivery
Priority given to preventive health care services	Priority given to curative health services
Surveillance of communicable diseases present	Surveillance of communicable diseases is not under control of family physician
There is strong cooperation between the other sectors	There is no cooperation between the other sectors
Referral chain available	Referral chain is not available
Targeting community participation	Targeting individual participation
Based on civil service	Based on contract employment
Based on solidarity between physicians	Based on competition between physicians
Moderate work load	Work load is higher
Working with low wages	Working with high wages
Fewer audits	More audits
Free of charge service	Paid services per visit (1 USD)
Insufficient physical infrastructure	Sufficient physical infrastructure
Sufficient legislation	Insufficient legislation
Technological facilities (internet, phone, computer, electronic recording, etc.) are not sufficient	Technological facilities (internet, phone, computer, electronic recording etc.) are sufficient

According to health care administrators and service providers, FHCs are preferred because of the close attention of the physician, confidence in the physician, preventive health services, proximity, and rescription of regular drugs. According to patients, FHCs are preferred for therapeutic purposes and rescription of regular drugs. Health centers were the first choice according to all groups for preventive health care services and rescription of regular drugs. For patients living in a rural area, there was no difference between the 2 periods in physician examination; the reason for this is that the same physicians continued to serve in rural areas.

"Nothing has changed for us. Because our doctor did not change, all the same. But, there may be some advantages in Manisa city center."

Patient, Female, 40-year-old, Rural

All participants reported the right to choose their physicians and physicians devoting more time to the patients as important advantages of the FP system. However, health care workers complained about the workload and stress. In particular, midwives and nurses emphasized the financial implications of this system, with funding made contingent on patient satisfaction, and payment per person.

"Choosing the physician is of course an advantage. If not satisfied, one can go immediately. We have to make people satisfied... We cannot make a sour face. And when we do so, the people can go and choose another physician... Indeed, I am not so delighted about this family practice thing, what we do is too much work and less money. Salaries are not sufficient, how many there were, we were 5 midwives, and now I do all of their job. I get so tired... It is hard work."

Midwife, 47-year-old, Rural

"Personal relations were better in FP system. Because it is money which is at stake. They show more care to keep the population."

Midwife, 47-year-old, Rural

According to health care administrators, physicians, midwives-nurses, and service users, the accessibility of FHCs is better compared with HCs. Because of the small number of available rooms and large population, waiting times were longer in the period of HC and accessibility via phone was better in the FP period. The patients consider the FP period more reliable compared with the HC period because of being examined by the same doctor.

"I ...have more close communication with my doctor in the FP period. I can explain my disease and discomfort without hesitation. But, we had some hesitations in the HC period due to facing different physicians every time. We did not know to whom we could express ourselves."

Patient, Female, 24-year-old, Rural

However, health care administrators and workers expressed that it is not a community-based service but rather an individual-based service which is provided in the FP period, and community-based services were better in the HC period.

"There was a community-based perspective in the HC period. You already deal with individual people when you deal with the community. You provide good service to the public if you serve the people well."

Physician, Male, 53-year-old, Rural

"We could do more if we found more time, but we cannot spare time due to work load. We cannot even visit patients outside. This is why we cannot provide a service to the public. We only deliver a service to those who come to the clinic. We make it happen if they come to us."

Midwife, 49-year-old, Rural

The administrators and midwives/nurses expressed that regional planning in the HC period was superior to the patient list practice in the FP period.

"... the site itself is a very important factor. If you provide community-based service, you must make an assessment on a larger scale, including where the water comes from, how hygienic is the water, what is the socio-economic status, all change by region. Regional planning is a must."

Manager, Female, 49-year-old, Rural

"Regional planning was better in the HC system. You get acquainted with the patient in regional planning. You know where and how to find them when you get on the field. It is now difficult to reach the patient, all are continuously moving."

Midwife, 51-year-old, Rural

Health care administrators, physicians, and midwives-nurses reported that more house visits were performed in the HC period.

"We took much care about in HC period. We visited more houses, now there is no time to do house visits. We already serve as one person; we rather call them to the clinic to give service. If I have gone to the field,

nobody would be left here to work. We gave better service before. We knew their houses. It has been 3-4 years; I do not know houses of many people. But, I have got their phone numbers. They come to the clinic when I call them."

Midwife, 49-year-old, Rural

"Babies, children, pregnant women were under follow-up at those times (HC period). The elderly received care at home. Not that many house visits are performed in FP period. The reason is there is only one midwife."

Patient, Female, 24-year-old, Rural

Health care administrators and physicians reported that regular follow-ups were similar in the 2 periods; however, there are some deficiencies, in that follow-ups not included in performance analysis (particularly in family planning services).

"Family planning services were given, vaccinations were performed, and environmental health studies were performed in HC period. There was no defect in this respect."

Physician, Male, 54-year-old, Urban

"Family planning services were better in the HC period... There is no service now; everything is laid on the patient him/herself. I remember we were handed out condoms, etc."

Patient, Male, 24-year-old, Urban

Health care administrators, workers, and service users expressed the opinion that environmental health and surveillance of infectious disease services were better in the HC period compared to the FP period.

"Infectious disease services were better in HC period. I was aware of everything as the physician working in a HC... We were aware of every step of a suspicious rabies case from dispatching the dog to the veterinary to its follow-up. It is not the case anymore, if there is a suspicious bite, the patient goes to state hospital to have the shots. We are only informed of the case."

Physician, Male, 54-year-old, Urban

"For example, they audited me (street food seller) in the HC period. They audited coffee houses. They do not audit anymore. If this is something about health, then health care facilities must deal with it. I think the government made a mistake here. HC dealt with such thing at those times, I think it was better."

Patient, Male, 62-year-old, Rural

All participants reported that physical conditions, technical equipment such as computer and Internet access, and laboratory facilities in the FP period were superior compared to the HC period, and that physical and technical infrastructure was not sufficiently supported in the HC period.

3.2 | Health staffing

Health care administrators and all workers reported a lack of team spirit in the FP period, in that there are only 2 persons constituting the health care team, and no one is available to replace absent staff.

"There is no team spirit, there is only one doctor and one midwife, that's all. There is no health officer, no environmental health technician. There was team spirit once in the era of HC. The team is made up of two people in the FP period, and I am physician and also the driver, that is too much ..."

Physician, Male, 53-year-old, Rural

Health care administrators reported that the FP system required competition, and physicians and midwives and nurses were not pleased with competition.

"Family practice brings competition between the staff. For some reason, however, physicians attempt to abolish it. They say that they make a gentleman's agreement. These are against the essence of the system..."

Manager, Male, 48-year-old, Urban

"Competition is not a pleasant thing in FP period. He/she had 4 thousand recorded patients, and I have 3 thousand patients. It is not pleasant, if I grab 3-5 patients from another. Competition is very bad. Grabbing patients is bad."

Physician, Male, 53-year-old, Rural

Likewise, medical staff expressed opinions opposed to fixed term insecure contracts (1 year), while health care administrators favored this type of contract.

"A fixed term contract is not a good thing ... employment security is important. The idea of being out of a job is a major source of stress."

Physician, Male, 54-year-old, Urban

"For me, a fixed term contract is a good thing. Many comments have been made supporting this. In my opinion, it is a public service if the government is paying for the costs. In the end, it is money paid by the government. I see no harm to family physicians if they work under fixed term contract. It can be continued year by year"

Manager, Male, 48-year-old, Urban

Health care administrators, physicians, midwives and nurses reported that population per doctor and workload was higher in the FP period.

"There is too much work to do in FP system. In that, this workload would be lower if an additional one or more auxiliary staff were assigned to each family physician. The family physician is doing all the job him/herself. They can not receive support in this regard."

Manager, Male, 48-year-old, Urban

3.3 | Health management

According to health care administrators and physicians, there was a lack of coordination, and execution problems, in community health centers established for the delivery of public health services in the FP period.

"I think the role of Community Health Centers must be clarified. A clear connection with the family physicians must be established. We are in the position of auditing their work. But they think we have no authority Community Health Centers must be reinforced in terms of authority."

Manager, Female, 40-year-old, Rural

Health care administrators reported that audits are better performed in the FP period and were only performed on paper in HC period.

"there were no audits in the HC period as in the current system. We had forms to be submitted. There was no feedback. That system could have been better if there was feedback and such controls..."

Manager, Female, 49-year-old, Urban

According to health care administrators and workers, personal records were better maintained in the FP period compared to the HC period because of availability of internet connection/computers, an electronic Family Physicians Information System, and frequent audits. The information was not readily available in the HC period because of

bureaucratic procedures and plenty of paperwork. However, patient data on the Family Physicians Information System are deficient and not up-to-date.

3.4 | Health finance

The wages of medical staff were better in the FP period compared to the HC period; in addition, staff were glad to work on a performance basis. Health care administrators reported that contribution rates must be reduced, while physicians and midwives/nurses thought that patients must pay contributions. However, the patients complained about contributions. In addition, health care workers and administrators expressed that payment on a performance basis increased service delivery.

"Well, we complain about contributions, it's not good. When we go to family physicians, the pharmacist charges us, we go to private health center, university hospital, they ask for money and you pay even if you go to a state hospital. The deductions are made from the salary."

Patient, Female, 56-year-old, Urban

"In the past, let us say a vaccine shot is to be given to a baby. ... the feeling of ownership is very different. Being under contract is another great factor. For any reason your contract may not be renewed. If 3 of 60 vaccines in the schedule are not performed, then there is a deduction due to poor performance, it is deducted from the salary. This also motivates. The midwives are better in their job than before."

Physician, Male, 54-year-old, Urban

"Performance-based payment must be in place. For example, although procedures included in the performance are performed as requested every month, only half of the services such as well-children follow-up, family planning, and follow-up of women aged 15-49 years are performed... positive performance indicators must be set and not only negative performance indicators."

Manager, Male, 48-year-old, Urban

We also summarized the main findings of this study according to health staff, managers, and patients in Figure 2.

4 | DISCUSSION

4.1 | Interpretation in relation to the existing literature

The participants reported that a community-based service was provided in HC period, and an individual-based service was provided in the FP period. Lack of regional planning and workload are basic factors for the provision of health care services only to those presenting to the facility. In the study by Baysal and Nur in the study by Ciceklioglu and Aktan, regional planning was more beneficial in the HC period.⁶⁻⁹ In the study by Ocek and Freeman, registered patient lists did not work properly in places with migratory movements in and out of the region in FP period, during which regional planning was superior.^{10,11} Regional inequities were higher in some studies.^{12,13}

House visits were frequent in the HC period; however, according to administrators, physicians, and midwives/nurses, house visits are performed when required in the FP period. House visits were less frequent in the studies.^{6,7,14-16} As indicated by the participants, the workload is too high and there is no substitutes for absent staff in the FP period. The patients are therefore contacted by phone or when they present to the health care facility. According to participants, there were no differences between FP and HC periods in preventive and therapeutic health care services and follow-ups, while services not included in the performance analysis were lower in FP period in the studies.^{6,8-10,17-20} The services in the HC period were mostly based on individual efforts. The services in the FP period were based on performance status in the studies by Nur et al, Baysal et al, Ilgun and Sahin 2016, and Nesanir

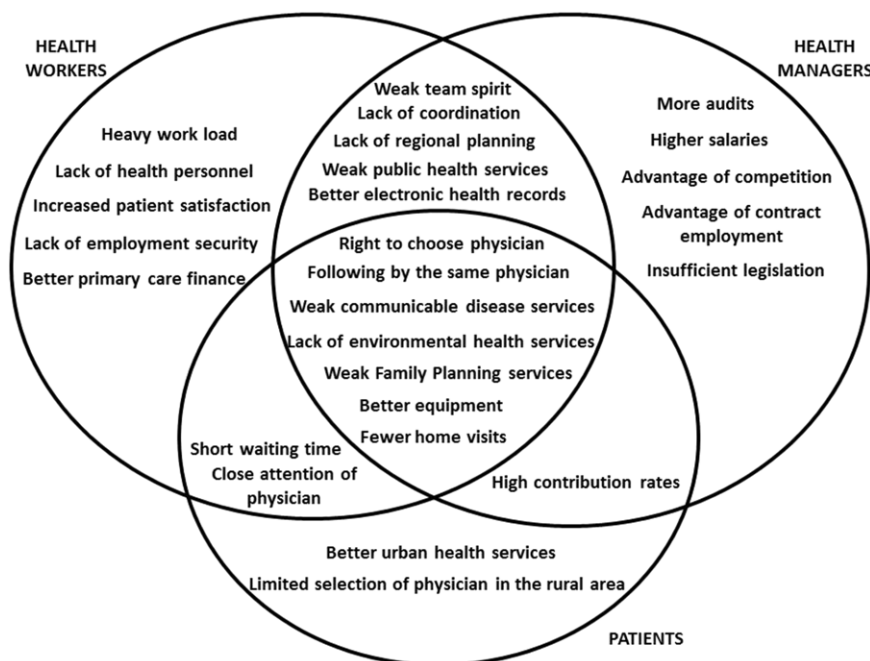


FIGURE 2 Main findings of the study according to health staff, managers, and patients

and Erkman, while the services in HC period were based on the efforts of the workers in other studies.^{6,7,16,18,21} However, the deficiencies in follow-up continue because of lack of regional planning and house visits. Thus, in the study by Durusoy conducted in İzmir, some pregnant women did not know their family physicians and some were not registered to any family physician.²² In the study by Kisa, follow-up of pregnant women, well-baby follow-ups, and vaccination status were high because of the pressure of negative performance assessment, and there is a performance penalty for delays in vaccination even in premature babies, and this pressure distorts reporting by physicians.²³ Health care workers and service users suggested that family planning services were better in the HC period compared to the FP period, during which there was a shortage of consumables. In the studies by Ozcan and Eren, the FP period negatively affected family planning, and in the study by Ocek, there are some problems of interpretation because of the fact that family planning services were not reflected in the performance analysis.^{10,24,25} According to data from the Turkish Statistical Institute for 2011, the decrease in Mother and Child Health and Family Planning Centers explains this finding.²⁶ The decrease in the number of these centers can also explain failures in service delivery. When it comes to filiation studies, physicians and midwives-nurses expressed that there were fewer filiation studies performed compared to the number performed in HC period. The causes of this include lack of coordination between family physicians and community health centers, lack of clear descriptions for the duties of community health centers, lack of sufficient support to the community health centers in management and staffing, and lack of regional planning in FP system. Similarly, in the studies by Eser et al, Lagarlı et al, Tanir, and Ocek et al, there was a lack of coordination between the institutions, and in the study by Eskioçak and Kringos et al, the hierarchy between community health centers and family physicians was disrupted, and cooperation between these service branches disappeared.^{15,27-31}

The reason for health care workers choosing family practice is mostly higher wages, and this finding is consistent with the findings in other studies.^{6,7,10,16,18,31-33} The administrators and medical staff indicated that salaries were higher in the FP period compared to the HC period, and this is consistent with the findings in previous studies.^{10,18} Hence, Ocek and Nesanir's studies emphasized that family practice is provided with a greater support in personnel

and physical infrastructure. Health care workers agreed on the lack of fixed term contract as a concern, while administrators advocated fixed term contract for service delivery, in contrast to medical staff.^{6,7,34,35} This, however, causes fear of job loss and uncertainty in medical staff. Similarly, in the study by Omac and Sevindik, health care workers were not pleased with fixed term contracts.³⁶ Performance-based service delivery does not promote teamwork. In the present study, administrators and medical staff had similar opinions. Patient-oriented, admission-based service is not an efficient and high-quality service delivery. In the studies by Wang 2015, conducted in Cuba, and Macinko and Matthew 2015 conducted in Brazil, primary health care services were associated with better outputs relative to the economic strengths of the developing countries adopting community-based and comprehensive health care services; therefore, it appears that family practice in these countries is superior to family practice as practiced in the United States.^{37,38} According to all participants, there was a team spirit in the HC period, and no team spirit is observed in FP period. Team spirit was lower in the studies by Ilgun and Sahin, Lagarli et al, Tanir, Ocek et al, Nur et al, and Baysal et al and where there was no team work, there was an increased work load, team work was replaced by employer-employee relationship, and the staff performed tasks beyond their core professions in many studies.^{6,7,15,16,30-32} In their study, Kringos et al stated that team spirit was vanished, and both Anderson and Warren and Torppa et al reported that family physicians acted with the reasoning of a business manager or entrepreneur.^{29,34,39} The decrease in team spirit causes competition and efforts to "grab" patients. However, clarifying that there is sufficient population for each family physician has led to agreements between the physicians. This abolishes the right of doctor choice that is regarded as the fundamental element of the system.

All interviewed groups indicated that physical conditions, technical equipment, and laboratory facilities are better in the FP period, and particularly in rural areas, patients reported that laboratory facilities were superior in the HC period. In the study by Ocek et al, conditions were better in FP period; however, the HC system served better in rural areas.¹⁰ People living in rural areas have to go to the county town to receive service, and this brings problems in accessibility.⁴⁰ Health care workers expressed that the government transferred its responsibilities onto family physicians in physical property and technical equipment, and lack of sufficient supply to the community clinics in that era has dragged the system to an inevitable change.

In the FP period, the reason for attendance is greater attention, confidence, preventive services, and rescription of regular drugs. In the studies conducted by Tanir in Adana, Aycan et al in Ankara, and Ocek et al in İzmir, Yama, and Gunes, in cities in Turkey, family physicians were mostly preferred because of preventive health care services and rescription of regular drugs.^{10,15,41,42} According to participants, HC were mostly preferred for preventive health care services, rescription of regular drugs, examination, and moderate health problems; in the study by Ciceklioglu and Aktan et al, community clinics are mostly preferred for preventive health care services.^{8,9} The waiting times were longer in the HC period because of lower number of outpatient clinics compared to FP period. Hence, in the studies by Baris et al, Atun et al, and Akturk, the increase in the number of outpatient clinics and technological utilities has increased number of examinations and patient satisfaction.^{1,2,43} In rural areas, patients are examined by the same doctor because of lack of opportunity to choose a physician. Family physicians do not offer a difference in doctor choice. According to the current research, family physicians recognize their patients because of the presence of a registered population, and computer and Family Physicians Information System resources. The participants argued that physicians devoted more time to their patients because of fear of losing the patient as well as performance analysis, and an official relationship existed between the patient and the physicians because patient is examined by the same physician on every admission. In the study by Tanir, family physicians were more attentive to their patients, and in the study by Ocek et al, recognizing and embracing the patients is more pronounced in FP period.^{10,15}

Doctor choice is regarded as an advantage by both medical staff and patients. However, health managers suggested that distinguishing the fact that there is sufficient population for each family physician has led to agreements between the physicians in the acceptance of the patient. This abolishes the right of choosing a physician, which is regarded as the fundamental element of family practice.

The administrators, physicians, and patients said that accessibility was better in the FP period; however, nurses and midwives said that accessibility was similar, but family physicians were not accessible during mobile services and out of working hours. Inaccessibility out of working hours is also noted as a drawback in other studies. This is similar in the study conducted by Tanir.¹⁵ Apart from these, the study by Ocek et al suggested that the accessibility reduced with increasing population.¹⁰ All participants agreed that accessibility via phone was better in the FP period compared to the HC period.

The waiting times were longer in the HC period compared to FP period according to administrators, physicians, and nurses. Fewer outpatients, and patient density, come to forefront. In the studies by Baris et al and Atun et al, increasing the number of outpatient clinics and improving technological utilities in FP period have increased repeated examinations by the same doctor, leading to increased patient satisfaction, and in the study by Ocek et al, the patient is seen and recognized by the same doctor with successive examinations.^{1,2,10} A referral chain was not implemented in either system. Thus, in another study, rate of referrals partially increased compared to the HC period, but a referral chain could not be implemented in the FP period.²⁵ The administrators and service users showed willingness to use a referral chain, while physicians and nurses rejected the use of a referral chain because of concerns about increasing work load. Similarly, in the study by Ocek et al, Ciceklioglu et al, and Aktan et al, all participants agreed that the system would collapse if a referral chain came into effect, and a referral chain was not implemented in the study by Ocek et al.⁸⁻¹⁰ The studies by Nur et al, Baysal et al, Nesanir et al, Eskiocak et al, and Ocek et al indicated excessive population and work load.^{6,7,18,28,31} In the FP period, the Family Physician's Information System and computer facilities provide convenience in rendering these services. In the studies by Baris et al, Atun et al, Nur et al, and Baysal et al, physical and technical conditions were better in the FP period, and more funds were allocated in FP period.^{1,2,6,7,44} All workers and administrators expressed their appreciation of funding, and there are more studies supporting this finding.^{6,7} Two studies conducted by Kilic et al reported insufficient physical infrastructure in HC period; the study by Gursoy et al reported technological deficiencies; the study by Ekuklu and Saltik reported severe defects in HC in equipment, and another study by Kilic et al conducted in Ankara reported deficiencies of HCs in information technology and technical equipment.^{21,45-47}

According to all participants, population per family physician is high in both FP and the HC periods. The administrators, physicians, and nurses considered that the quality and reliability of patients' records were improved in the FP period because of availability of the Family Physician Information System and computer facilities, while some administrators expressed that not all records were up-to-date because of insufficient house visits in the FP period. Excessive paperwork and lack of technological resources in the HC periods show the maintenance of personal records in the FP period in a positive light. However, because of more widespread use of technology such as internet, computers, and cell phones, this may be an inaccurate interpretation of HC period.⁴⁸

The administrators and health care workers report that the legislation around family practice has some defects and delays, and they suggest that physicians and nurses fear loss of their job and feel that they are not sufficiently cared for by their employer. In the studies by Nur et al, Baysal et al, Tanir, Ilgun and Sahin, and 1 study that was conducted in Sivas, Erzurum, Adana and Ankara, health care workers expressed their concerns about future.^{6,7,15,16,31} In the HC period, socialization legislation was a good legislation for its time but was not implemented as it deserved, and this necessitated transition to a new system. Therefore, there may still be some defects.⁴⁹

4.2 | Limitations

The limitations of the study are as follows: The number of administrators that worked in the 2 periods was low, administrators and workers were not willing to spare time to the study because of time constraints, and the retrospective nature of the study means that individuals may not have accurately recollected their experience of the earlier system.

TABLE 2 Main themes of the study for family physician period in Turkey

Main Codes	Themes
Doctor choice available Higher patient satisfaction Patient lists (no geographical area) Per-capita service	Individualization
Based on contract employment Based on competition between physicians Heavy work load High contribution rates Lack of employment security Pay for performance	Globalization
Shorter waiting times Following by the same doctor Close attention of physician Sufficient physical and technical infrastructure Better electronic health records High salaries	Better primary care services
Weak surveillance of communicable diseases Weak family planning services Weak environmental health services Fewer house visits	Weak public health services
Lack of coordination between the physicians Lack of cooperation between the other sectors Weak team spirit	Weak management

5 | CONCLUSION

The present study found that the HC and the FP periods have specific strengths and weaknesses.

In general, the strengths of FP system can be summarized as follows: Both health care staff that worked in the 2 periods and the public that received health care services in the 2 periods reported that FP period was superior to HC period in attention showed by the family physicians, being followed by the same physician, and having confidence in physicians. Therefore, family health centers have become a more frequent place for first admission. The waiting times are also shorter than before. Family health centers are superior to HC period in facilities such as patient records, computer, internet, and phone. Health care workers felt that payment on a performance basis improved service delivery. Starfield noted that the result of performance-based payment can only be an increase in measuring the measurable and physicians will do what they are paid to do.⁵⁰

In general, the strengths of HC period can be summarized as follows: According to health care workers who worked in the 2 periods and the people who received service in the 2 periods, house visits, environmental health studies, and family planning were better in the HC period. According to staff, HC were superior to FP in team spirit, public service delivery, and surveillance of infectious diseases. The team spirit inside modern health care services is 1 of the most important features differentiating modern health care services from traditional health care services. However, in the FP period, services are provided primarily by physicians, and only 1 health staff member (nurse, midwife, or nurse-midwife) is working together with the physician. This cannot compensate for the superior team work in HC period.

Being the place of first admission for mild health problems and represcription of regular drugs, insufficient pre-service and in-service training, and lack of a working referral chain are similar aspects of the 2 periods. The qualitative themes in the research were coverage, continuous health service, health team, communication, referral system, registrations, legislation, finance, management, education, and community participation.

In the present study, the concept of FP period embodies the concept of patient choice, and use of advanced technology. Considering international advances, the first theme coming out of this research is individualization and globalization. Two additional themes are "primary care" and "public health" services. A contrast between better primary care services but weaker public health services emerged from this study (Table 2). These themes determine

the sustainability and accessibility of the services. That is why health managers and policy makers should work together to strengthen health services.

5.1 | Recommendations

The population per family physician must be reduced because of excessive workload. This may improve preventive health care services and follow-up of risk groups. A geographical region-based service delivery must be adopted in these follow-ups to gain familiarity with the population. Team spirit must be developed in FP system, and the teams must be enlarged in an attempt to reduce workload. These will lead to a better service, better morale, fewer days of absence, reduced stress, and increased retention of staff. In addition, family physicians must provide family planning services and infectious disease surveillance. Public service delivery and environmental health studies and health service in rural areas (house visits, laboratory services, etc.) must be scrutinized in the context of the FP system. The complaints of the people about contributions must be taken into consideration. The lack of coordination and cooperation should be considered by health managers.

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CONFLICT OF INTEREST

The authors have no competing interests.

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